Jackson Chiropractic Clinic

Jackson Chiropractic Clinic
3508 Rice Street N
St. Paul, MN 55126
(651) 483-4321

Patient Information

Contact Information

Name _____ Nickname _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Cell Phone (_____) _____ Work Phone(_____) _____

Email Address _____

Sex M / F Birth Date _____/_____/_____ Age _____

Marital Status S / M / D / W Number of Children _____

Work/School Information

Occupation _____ Place of Employment _____

Address _____

Work Status PT / FT Student Status PT / FT School Name _____

Insurance Information

Insurance Company _____

Policy Holder Self / Spouse / Parent

Policy Holder Name _____ Birth Date _____/_____/_____

Today's Visit

What's bringing you in today? _____

When did your symptoms start? _____

Have you seen other chiropractors recently or in the past? If yes, please list: _____

_____

Referred by: _____

Jackson Chiropractic Clinic

PEDIATRIC HEALTH HISTORY
6-10 years old

Identification Information

Full Name _____ Nickname _____
Last First MI

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female

Guardian(s) Name & Relationship _____

Address_____

City _____ State _____ Zip Code _____

Phone Number _____ ☐ Home ☐ Cell ☐ Work

Insurance Information

Insurance Company _____ ☐ I do not have insurance.

Policy Holder: ☐ Self ☐ Spouse ☐ Parent

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Child History

Reason for today's visit: _____

How did this begin? _____ When did it start? _____

Was the onset: ☐ Sudden ☐ Gradual Is the problem: ☐ Constant ☐ Intermittent

Have you had this before? ☐ Yes ☐ No _____

Have you been treated for this problem? ☐ Yes ☐ No By whom? _____

Do you have any: ☐ Back pain ☐ Neck pain ☐ Arm pain ☐ Leg Pain ☐ Headaches

Any recent falls or trauma? ☐ Yes ☐ No _____

Have you fallen down stairs or from a significant height? ☐ Yes ☐ No _____

Have you been in a motor vehicle collision or near-miss? ☐ Yes ☐ No _____

Please list any injuries, surgeries, or hospitalizations: _____

_____

LIFESTYLE

What grade are you in at school? _____ How do you carry your school books? _____

What sports/hobbies do you have? _____

How much "screen time" do you have? _____ hours How much do you sleep at night? _____ hours

HEALTH HISTORY

Do you have frequent upper respiratory infections? ☐ Yes ☐ No If yes, how often? _____

Do you have a history of ear infections? ☐ Yes ☐ No

If **yes**: At what age(s)? _____ Which ear? ☐ Right ☐ Left ☐ Both

What was the treatment? _____

Do you have any persistent or intermittently occurring skin rashes? ☐ Yes ☐ No _____

Do you wear glasses or contact lenses? ☐ Yes ☐ No Do you ever have blurred vision? ☐ Yes ☐ No

Do you have trouble reading the board in class? ☐ Yes ☐ No

What do you usually eat for:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Do you eliminate stools every day? ☐ Yes ☐ No

Allergies (medication or environmental): _____

Please list all medications (prescription and non-prescription) and all nutritional/herbal supplements you are taking, plus the dosage and frequency:

_____

_____

Have you been to a chiropractor before? ☐ Yes ☐ No

Guardian Signature _____ Date _____

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Shoreview, MN 55126
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Authorization for Care of a Minor

Patient's Name _____ Date of Birth _____

Parent/Guardian Name(s) _____

Relationship _____ Phone Number _____

I, hereby, authorize Jackson Chiropractic Clinic to render any chiropractic services necessary for the treatment of _____. These services include but are not limited to: physical examination, x-rays, chiropractic adjustments, therapeutic procedures, traction, electric muscle stimulation, and manual muscle work, within the scope of chiropractic practice.

I, hereby, give consent for _____ to be treated even if I or another parent is unable to attend the chiropractic visit. As a parent/guardian, I am financially responsible for any services rendered during the visit. Any questions or concerns can be directed toward the treating doctor at any time.

Parent/Guardian Signature _____ Date _____

As a Doctor of Chiropractic, we will perform services to the best of our ability, upholding the integrity of our practice. We will treat the patient with respect and only perform services we deem necessary for the treatment of the condition.

Doctor Signature _____

Doctor Name _____ Date _____

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Receipt of Notice for Privacy Practices

I hereby acknowledge receipt of the Notice of Privacy Practices for Jackson Chiropractic Clinic regarding my health information. I have been informed and understand the manner in which my health information shall be maintained, utilized, and disclosed by the Clinic and my respective rights therein. I also understand that the Notice furnished to me is subject to change at any time. I am aware that I may obtain a current copy of this Notice at any time by contacting (651) 483-4321.

My signature below herein constitutes acknowledgment that I have been furnished a copy of the Notice of Privacy Practices for Jackson Chiropractic Clinic.

Payment Agreement

I authorize the release of any medical information necessary to process insurance billings.

I authorize payment and assignment of insurance benefits to the doctor's office.

I am personally responsible for supplying accurate and current information.

I understand I am financially responsible for all charges and deductibles not covered by my insurance and/or if I supply false or incorrect billing information. I authorize a photocopy of this statement to serve as an original.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____

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Informed Consent Document

Please read this entire document prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.

Nature of Chiropractic Care. The primary treatment used by Doctors of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way to move your joints. That may cause an audible noise, and you may feel a sense of movement.

Analysis, Examination, Treatment. As part of the analysis, examination, and treatment, you are consenting to the following procedures, but not limited to:

- Spinal manipulative therapy
- Palpation
- Vital signs
- Range of motion testing
- Orthopedic testing
- Basic neurological testing
- Radiographic studies
- Therapeutic ultrasound
- Hot/cold therapy
- Electric muscle stimulation

Risk Inherent with a Chiropractic Care. As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. The Doctor will make every reasonable effort during the examination to screen for contraindications of care. These complications include, but are not limited to: muscle strain, burns, fractures, disc injuries, dislocations, cervical myelopathy, and costovertebral stains and separations. Some patients will feel some stiffness and soreness following the first few days of treatment.

Other Available Treatment Options. Other treatment options for your condition may include self-administered over-the-counter analgesics, rest, medical care, prescription drugs, hospitalization, and surgery. If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physicians.

Risk of Remaining Untreated. Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult and less effective the longer it is postponed.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my care provider(s) and have had my questions answered to my satisfaction. By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name: _____

Patient Signature: _____ Date: _____

Signature of Parent of Guardian (if a minor): _____

Doctor Name: _____

Doctor Signature: _____ Date: _____